Released 10/04/99.

Department of Health and Human Services
Public Health Service Commissioned Corps

# REIMBURSEMENT REQUEST FOR ADOPTION EXPENSES

*(Please read Privacy Act Statement and Application Processing Instructions on page 3 before completing this form.)*

## SECTION I - COMMISSIONED OFFICER INFORMATION

| 1. NAME OF ACTIVE DUTY OFFICER *(Last, First, Middle Initial) (Print or Type)* | 2. SOCIAL SECURITY NUMBER | 3. PHS SERIAL NUMBER |
|---|---|---|
| 4. MARITAL STATUS *(Check one)* Single ☐ Married ☐ Divorced ☐ | | 5. PAY GRADE |
| 6. OPERATING DIVISION / PROGRAM | 7. HOME TELEPHONE NUMBER | 8. WORK TELEPHONE NUMBER |
| 9. HOME ADDRESS *(Include 9-digit ZIP Code and Apartment number, if applicable)* | 10. STATE OF LEGAL RESIDENCE | |
| | 11. ANY PREVIOUS REIMBURSEMENT CLAIMED FROM A UNIFORMED SERVICE IN CURRENT CALENDAR YEAR? *(Check one)* ☐ Yes ☐ No | |

## SECTION II - SPOUSE INFORMATION

| 12. IS SPOUSE A MEMBER OF A UNIFORMED SERVICE? *(Check one)* ☐ Yes ☐ No | 13. IF ANSWER TO ITEM 12, IS YES, PROVIDE THE FOLLOWING SPOUSE INFORMATION: | |
|---|---|---|
| | a. Name of Spouse *(Last, First, Middle Initial)* | b. Branch of Service |
| | c. Social Security Number | d. Serial Number |

## SECTION III - ADOPTION INFORMATION

| 14. DATE OF HOME STUDY *(MM/DD/YYYY)* | 15. DATE CHILD PLACED IN HOME *(MM/DD/YYYY)* | 16. DATE ADOPTION FINALIZED *(MM/DD/YYYY)* |
|---|---|---|

17. NOTES
- a. The adoption must have been finalized on or after November 18, 1997.
- b. Adoption expenses by non-active-duty members or members on active duty less than 180 days are not allowable for reimbursement.
- c. Reimbursement of adoption expenses may be paid only after the adoption is final. Members who leave active duty before the final adoption decree is granted are not entitled to be reimbursed.
- d. Reimbursement claims must be submitted no later than 365 days after adoption is finalized.

| 18. NAME OF ADOPTED CHILD *(Last, First, Middle Initial)* | a. Date of Birth *(MM/DD/YYYY)* | b. Sex *(Check one)* ☐ Male ☐ Female |
|---|---|---|

19. ADOPTION ARRANGED BY *(Documentation attached) (Check one)*

☐ a. A State or local government agency that has responsibility under State or local law for child placement through adoption.

☐ b. A nonprofit, voluntary adoption agency that is authorized by State or local law to place children for adoption.

20. EXPENSES INCURRED *(Complete as applicable and attach documentation)*

| | |
|---|---|
| a. Public and private agency fees. | $ |
| b. Placement fees, including fees charged adoptive parents for counseling. | |
| c. Legal fees, including court costs. | |
| d. Medical expenses, including hospital expenses for the newborn infant, for medical care furnished the adoptive child before the adoption, and for physical examinations of the biological mother of the child to be adopted. | |
| e. Expenses relating to pregnancy and childbirth for the biological mother, including counseling and maternity costs. | |
| f. Temporary foster care charges when such care is required for the placement of the adoptive child. | |
| g. Subtotal of expenses listed above *(Items 20.a. through 20.f.).* | |
| h. Amount of reimbursement previously applied for and/or received under any other adoption benefits program administered by the Federal government or under such program administered by a State or local government. | |
| i. Total expenses *(Subtotal (Item 20.g.) minus any reimbursements in Item 20.h.).* | |

## SECTION IV - ACTIVE DUTY OFFICER'S CERTIFICATION

I certify that the information and expenses in Sections I through III are true and correct to the best of my knowledge. I understand and agree that reimbursement of expenses is limited to $2,000 per adopted child with maximum reimbursement of $5,000 in any calendar year to a member, or couple where both spouses are members of the Uniformed Services. I recognize that this benefit is taxable and shall be reported as income subject to tax. I agree not to seek further reimbursement under this program for the adoption of this child.

I further certify that neither I nor my spouse have received a reimbursement under any other adoption benefit program administered by the Uniformed Services. To the best of my knowledge, I am the only active-duty member of the Uniformed Services claiming reimbursement of $ _____ .

| 21. OFFICER'S NAME *(Last, First, Middle Initial) (Print or Type)* | a. Officer's Signature | b. Date of Signature *(MM/DD/YYYY)* |
|---|---|---|
| | | |

## SECTION V - OPERATING DIVISION/PROGRAM AUTHORIZATION AND CERTIFICATION FOR ADOPTION EXPENSES

I certify that, based upon information provided and documentation attached, the below named individual is eligible for reimbursement of adoption expenses.

| 22. NAME OF ACTIVE DUTY OFFICER *(Last, First, Middle Initial) (Print or Type)* | 23. SOCIAL SECURITY NUMBER |
|---|---|
| | |

| 24. TITLE OF CERTIFYING OFFICIAL *(Print or Type)* | |
|---|---|
| a. Typed Name | b. Work Telephone Number |
| | |
| c. Signature | d. Date Signed *(MM/DD/YYYY)* |
| | |

| 25. DUTY STATION ADDRESS | 26. OPERATING DIVISION/PROGRAM |
|---|---|
| | |

## APPLICATION PROCESSING INSTRUCTIONS FOR COMPLETING FORM PHS-7036 "Reimbursement Request for Adoption Expenses"

1. Administrative personnel of the officer's Department of Health and Human Services' (HHS) Operating Division (OPDIV) or the Program (Bureau of Prisons, U.S. Coast Guard, etc.) to which the officer is assigned will assist in completing this application for reimbursement. The Compensation Branch of the Division of Commissioned Personnel (DCP) will provide any additional guidance needed concerning this program. The Compensation Branch, DCP, can be reached at telephone number 301-594-2963.

2. The officer will provide documentation supporting any final court papers, and all substantiating receipts with the claim. The officer must submit certified copies of original court documents. Documents will *not* be returned to the officer.

3. Claim forms may be signed by the officer's spouse under a power of attorney, which must be attached to this form.

4. The officer must retain copies of all related paperwork until the claim is paid or denied.

5. When this reimbursement request with documentation is complete, the officer's OPDIV/Program will certify as to the validity of the claim by completing Section V - Operating Division/Program Authorization and Certification for Adoption Expenses.

6. Submit the completed form and attachments to:
   Division of Commissioned Personnel/HRS/PSC
   ATTN: Compensation Branch
   5600 Fishers Lane, Room 4-50
   Rockville, MD 20857-0001

7. If eligibility for reimbursement cannot be determined from the documents provided or claimed expenses are not properly supported by receipts, the Compensation Branch, DCP, will retain the claim and request the necessary information or documentation. This information and/or documentation must be submitted within 90 days for the claim to be reconsidered.

8. If the claim is denied, a letter stating denial will be sent to the officer's address in section I, item 9, of this form. The claim and attachments will not be returned to the officer.

9. If the claim is approved, it will be processed with the regular commissioned corps payroll.

---

## PRIVACY ACT STATEMENT

| | |
|---|---|
| AUTHORITY: | 5 U.S.C. 5701-5742, 37 U.S.C. 404-427, E.O. 9397, AND P.L. 102-190, SECTION 651. |
| PRINCIPAL PURPOSE(S): | Used for reviewing, approving, accounting, and disbursing for adoption reimbursement. The Social Security Number is used to maintain an numerical identification system for individual claims and tax reporting purposes. |
| ROUTINE USE(S): | None. |
| DISCLOSURE: | Voluntary; however, failure to furnish information requested may result in total or partial denial of amount claimed. |
| RECORDS SYSTEM: | 09-37-0002, "PHS Commissioned Corps Personnel Records," HHS/OASH/OSG. |